City of San Jose
Active Employees and Early Retirees
Group# MH0241
Custom POS℠ 100/90/70

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective January 1, 2011

DEDUCTIBLES[1]	**LEVEL I: HMO Plan Providers**[2]	**LEVEL II: Preferred Providers**[2]	**LEVEL III: Non-Preferred Providers**[2]
Calendar year medical deductible	None	$100 per individual/$200 per family	
Calendar year copayment maximum[1] (For many covered services)	$1,500 per individual/ $3,000 per family	$1,500 per individual/ $3,000 per family	$4,500 per individual/ $9,000 per family
LIFETIME BENEFIT MAXIMUMS	None	None	

Covered Services	**Member Copayment**		
PROFESSIONAL SERVICES	**LEVEL I: HMO Plan Providers**[2]	**LEVEL II: Preferred Providers**[2]	**LEVEL III: Non-Preferred Providers**[2]
Professional (physician) benefits			
• Physician and specialist office visits Note: For network benefits provider level, a woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.	$25 per visit	$35 per visit (Not subject to the Calendar-Year Deductible)	30%
• Outpatient X-ray, pathology and laboratory	No charge	$35 per visit	30%
Allergy testing and treatment benefits			
• Office visits (includes visits for allergy serum injections)	$25 per visit	$35 per visit	30%
Preventive health benefits			
• **Routine physical examination office visit** (according to age schedule) Including the physical examination office visit, gynecological office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent. Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for annual gynecological exams.	No charge	Not covered	Not covered
• Immunizations (according to age schedule)	No charge	Not covered	Not covered
OUTPATIENT SERVICES			
Hospital benefits (facility services)			
• Outpatient surgery performed in an Ambulatory Surgery Center	$50 per surgery	$50 per surgery +10%	30%[3]
• Outpatient surgery in a hospital	$100 per surgery	$100 per surgery + 10%	30%[3]
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	No charge	10%	30%[3]
• Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity)	$100 per surgery	$100 per surgery + 10%[5]	30%[3, 5]
HOSPITALIZATION SERVICES			
Hospital benefits (facility services)			
• Inpatient physician services	No charge	10%	30%
• Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies)	$100 per admission	$100 per admission + 10%	30%[4]
• Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity)	$100 per admission	$100 per admission + 10%[5]	30%[4, 5]
• Inpatient medically necessary skilled nursing facility services including subacute care[6]	No charge	10%	30%[4]

EMERGENCY HEALTH COVERAGE			
• Emergency room services not resulting in admission (ER facility copay does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit	$100 per visit	$100 per visit
• Emergency room physician services	No charge	10%	10%
AMBULANCE SERVICES			
• Emergency or authorized transport	No charge	10%	10%
PRESCRIPTION DRUG COVERAGE **Outpatient prescription drug benefits[1]**	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Services .		
PROSTHETICS/ORTHOTICS			
• Prosthetic equipment and devices (Separate office visit copay may apply)	No charge	10%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	No charge	10%	30%
DURABLE MEDICAL EQUIPMENT			
• Durable medical equipment (of allowed charges, Level I only)	No charge	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	**LEVEL I: MHSA Participating Providers[2]**	**LEVEL II: N/A, except for medical acute detoxification**	**LEVEL III: MHSA Non-Participating Providers[2]**
• Inpatient hospital services	$100 per admission	N/A	30%[4]
• Outpatient mental health services	$25 per visit	N/A	30%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9], Please see footnote 8			
• Chemical dependency and substance abuse services	Not covered	Not covered	Not covered
HOME HEALTH SERVICES	**LEVEL I: HMO Plan Providers[2]**	**LEVEL II: Preferred Providers[2]**	**LEVEL III: Non-Preferred Providers[2]**
• Home health care agency services (up to 100 visits per calendar year)	$25 per visit	10%	Not covered[10]
• Medical supplies and laboratory services (For home self-administered injectable medications, see "Prescription Drug Coverage.")	No charge	10%	Not covered[10]
OTHER			
Hospice program benefits			
• Routine home care	No charge	Not covered[11]	Not covered[11]
• Inpatient respite care	No charge	Not covered[11]	Not covered[11]
• 24- hour continuous home care	No charge	Not covered[11]	Not covered[11]
• General inpatient care	No charge	Not covered[11]	Not covered[11]
Pregnancy and maternity care benefits			
• Prenatal and Postnatal physician services (For inpatient hospital services, see "Hospitalization Services.")	No charge	$35 per visit	30%
Family planning and infertility benefits			
• Counseling and consulting	No charge	Not covered	Not covered
• Infertility services(of allowed charges) (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%	Not covered	Not covered
• Tubal ligation[12, 13]	$100 per surgery	Not covered	Not covered
• Elective abortion[13]	$100 per surgery	Not covered	Not covered
• Vasectomy[13]	$50 per surgery	Not covered	Not covered
Rehabilitation benefits (physical, occupational and respiratory therapy)			
• Office location	$25 per visit	$35 per visit	30%
• Outpatient visits	$25 per visit	10%	30%
• Inpatient Skilled Nursing Facility (SNF)	No charge	10%	30%
• Inpatient Rehabilitation Unit of a hospital	No charge	10%	30%[4]
Speech therapy benefits			
• Office location	$25 per visit	$35 per visit	30%

Diabetes care benefits			
• Devices, equipment and non-testing supplies (of allowed charges, Level I only) (For testing supplies, please see "Outpatient Prescription Drug Coverage Summary.")	No charge	10%	30%
• Diabetes self-management training	$25 per visit	$35 per visit	30%
Hearing aid services			
• Audiological examination	No charge	$35 per visit	30%
• Hearing aid and ancillary equipment (Plan payment up to $1,000 maximum per member every 36 months)	No charge	No charge	No charge
Urgent care benefits			
• Urgent services outside your personal physician service area	$50 per visit[14]	See Applicable Benefit	See Applicable Benefit

Optional benefits[1] Optional dental, vision, infertility, substance abuse, chiropractic, or acupuncture/chiropractic benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred Providers accept Blue Shield's allowable amount as full payment for covered services. Non-Preferred Providers can charge more than these amounts. When members use Non-Preferred Providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or copayment maximum. Calendar-year deductible applies to services of Non-Preferred Providers only.

3 The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 30 percent of this $350 per day, plus all charges in excess of $350.

4 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 30 percent of this $600 per day, plus all charges in excess of $600.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Evidence of Coverage for further benefit details.

6 Skilled nursing services are limited to 100 preauthorized days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized-day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

7 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) – utilizing Blue Shield's MHSA Participating (Level I) and Non-Participating (Level III) providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. There are no Level II providers for mental health services, other than for medical acute detoxification. For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the Evidence of Coverage or Plan Contract.

8 **Optional substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**

9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's HMO Plan Providers (Level I), Preferred Providers (Level II), or Non-Preferred Providers (Level III).

10 Out of network home health care services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

11 Out of network hospice is not covered unless pre-authorized. When these services are pre-authorized, the member pays the Level I copayment.

12 Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery.

13 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

14 For Level I Services outside of California or the United States, Out-of-Area Follow-up Care is covered through any provider or through the BlueCard® Program participating provider network. However, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. For Level I Services outside your Personal Physician Service Area but within California, Member Services will assist the patient in receiving Out-of-Area Follow-up Care through a Blue Shield Plan Provider. To receive Level I Services, Blue Shield HMO may direct the patient to receive follow-up Services from the Personal Physician.

Plan designs may be modified to ensure compliance with state and federal requirements